		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0043711

Facility Name: OAKWOOD HEALTH CARE CENTER

Address: 605 E CHURCH ST-BOX 60 (Number) KEWANEE (City) 61443 (Zip Code)

County: HENRY

Telephone Number: (309) 852-3389 **Fax #** (309) 853-1838

IDPA ID Number: 830320180018

Date of Initial License for Current Owners: 2/7/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: William H. Keys **Telephone Number:** (317) 208-2740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Larry Bonds

(Title) President

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	200	Skilled (SNF)	200	73,000	1
2	0	Skilled Pediatric (SNF/PED)	0	0	2
3	0	Intermediate (ICF)	0	0	3
4	0	Intermediate/DD	0	0	4
5	0	Sheltered Care (SC)	0	0	5
6	0	ICF/DD 16 or Less	0	0	6
7	200	TOTALS	200	73,000	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	53	20	3,223	3,296	8
9	SNF/PED	0	0	0		9
10	ICF	22,027	10,035	0	32,062	10
11	ICF/DD	0	0	0		11
12	SC	0	0	0		12
13	DD 16 OR LESS	0	0	0		13
14	TOTALS	22,080	10,055	3,223	35,358	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 48.44%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A - None

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 2/7/1998

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/7/1998 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 200 and days of care provided 3,223

Medicare Intermediary TRAILBLAZER HEALTH ENTERPRISES, LLC

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	180,901	15,878	8,400	205,179		205,179		205,179			1
2	Food Purchase		162,644		162,644		162,644	(2,997)	159,647			2
3	Housekeeping	112,790	16,512		129,302		129,302		129,302			3
4	Laundry	62,506	21,889		84,395		84,395		84,395			4
5	Heat and Other Utilities			160,702	160,702		160,702	410	161,112			5
6	Maintenance	41,894	11,092	33,173	86,159		86,159	18,271	104,430			6
7	Other (specify):*			9,533	9,533		9,533		9,533			7
8	**TOTAL General Services**	398,091	228,015	211,808	837,914		837,914	15,684	853,598			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,271,514	75,520	28,891	1,375,925		1,375,925		1,375,925			10
10a	Therapy	64,937	47,576	278,158	390,671		390,671		390,671			10a
11	Activities	52,980	427	4,092	57,499		57,499		57,499			11
12	Social Services	68,397		2,804	71,201		71,201		71,201			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,457,828	123,523	313,945	1,895,296		1,895,296		1,895,296			16
	C. General Administration											
17	Administrative	77,318		2,220	79,538		79,538	2,086	81,624			17
18	Directors Fees											18
19	Professional Services			28,115	28,115		28,115	25,204	53,319			19
20	Dues, Fees, Subscriptions & Promotions			10,722	10,722		10,722	260	10,982			20
21	Clerical & General Office Expenses	115,429	29,935	228,232	373,596		373,596	63,549	437,145			21
22	Employee Benefits & Payroll Taxes			301,965	301,965		301,965	10,157	312,122			22
23	Inservice Training & Education											23
24	Travel and Seminar			17,589	17,589		17,589	920	18,509			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			115,991	115,991		115,991		115,991			26
27	Other (specify):*											27
28	**TOTAL General Administration**	192,747	29,935	704,834	927,516		927,516	102,176	1,029,692			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,048,666	381,473	1,230,587	3,660,726		3,660,726	117,860	3,778,586			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER #0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			238,006	238,006		238,006	1,077	239,083			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			293,738	293,738		293,738	(2,728)	291,010			32
33	Real Estate Taxes			54,817	54,817		54,817		54,817			33
34	Rent-Facility & Grounds			14,185	14,185		14,185	5,119	19,304			34
35	Rent-Equipment & Vehicles			10,731	10,731		10,731	411	11,142			35
36	Other (specify):*							286	286			36
37	TOTAL Ownership			611,477	611,477		611,477	4,165	615,642			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			5,689	5,689		5,689		5,689			38
39	Ancillary Service Centers		50,977	316	51,293		51,293		51,293			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,500	109,500		109,500		109,500			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		50,977	115,505	166,482		166,482		166,482			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,048,666	432,450	1,957,569	4,438,685		4,438,685	122,025	4,560,710			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,392)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(4,623)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(605)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,352)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(14,911)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule (See page 5a)	(733)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (28,616)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	150,641	Var	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 150,641		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 122,025		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

OAKWOOD HEALTH CARE CENTER

ID# 0043711

Report Period Beginning: 1/1/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4	Non-Patient Meals	(2,392)	2	4
5				5
6				6
7				7
8				8
9				9
10	Interest and Other Investment Income	(4,623)	32	10
11				11
12				12
13	Sales Tax	(605)	2	13
14				14
15				15
16				16
17				17
18	Fines and Penalties	(5,352)	21	18
19				19
20				20
21				21
22	Special Legal Fees & Legal Retainers	(14,911)	19	22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31	Other non allowable expense	(733)	30	31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(28,616)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,997)	0	0	0	0	0	0	0	0	0	0	(2,997)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	410	0	0	0	0	0	0	0	0	0	410	5
6	Maintenance	0	18,271	0	0	0	0	0	0	0	0	0	18,271	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,997)	18,681	0	0	0	0	0	0	0	0	0	15,684	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	2,086	0	0	0	0	0	0	0	0	0	2,086	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(14,911)	40,115	0	0	0	0	0	0	0	0	0	25,204	19
20	Fees, Subscriptions & Promotions	0	260	0	0	0	0	0	0	0	0	0	260	20
21	Clerical & General Office Expenses	(5,352)	68,901	0	0	0	0	0	0	0	0	0	63,549	21
22	Employee Benefits & Payroll Taxes	0	0	10,157	0	0	0	0	0	0	0	0	10,157	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	920	0	0	0	0	0	0	0	0	920	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(20,263)	111,362	11,077	0	0	0	0	0	0	0	0	102,176	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(23,260)	130,043	11,077	0	0	0	0	0	0	0	0	117,860	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 **Report Period Beginning:** 1/1/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(733)	0	1,810	0	0	0	0	0	0	0	0	1,077	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,623)	0	1,895	0	0	0	0	0	0	0	0	(2,728)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	5,119	0	0	0	0	0	0	0	0	5,119	34
35	Rent-Equipment & Vehicles	0	0	411	0	0	0	0	0	0	0	0	411	35
36	Other (specify):*	0	0	286	0	0	0	0	0	0	0	0	286	36
37	**TOTAL Ownership**	(5,356)	0	9,521	0	0	0	0	0	0	0	0	4,165	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(28,616)	130,043	20,598	0	0	0	0	0	0	0	0	122,025	45

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached Organizational Structure Description						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Senior Living Properties, LLC	100.00%	$ 0	$	1
2	V	2	Food Purchase		Senior Living Properties, LLC	100.00%	0		2
3	V	3	Housekeeping		Senior Living Properties, LLC	100.00%	0		3
4	V	4	Laundry		Senior Living Properties, LLC	100.00%	0		4
5	V	5	Heat and Other Utilities		Senior Living Properties, LLC	100.00%	410	410	5
6	V	6	Maintenance		Senior Living Properties, LLC	100.00%	18,271	18,271	6
7	V	7	Waste Removal		Senior Living Properties, LLC	100.00%	0		7
8	V	10	Nursing & Medical Records		Senior Living Properties, LLC	100.00%	0		8
9	V	10a	Therapy		Senior Living Properties, LLC	100.00%	0		9
10	V	17	Administrative		Senior Living Properties, LLC	100.00%	2,086	2,086	10
11	V	19	Professional Services		Senior Living Properties, LLC	100.00%	40,115	40,115	11
12	V	20	Dues, Fees, Subscriptions & Promotions		Senior Living Properties, LLC	100.00%	260	260	12
13	V	21	Clerical & General Office Expenses		Senior Living Properties, LLC	100.00%	68,901	68,901	13
14	Total			$			$ 130,043	$ * 130,043	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Benefits & Payroll Taxes	$	Senior Living Properties, LLC	100.00%	$ 10,157	$ 10,157	15
16	V	24	Travel and Seminar		Senior Living Properties, LLC	100.00%	920	920	16
17	V	26	Insurance - Prop Liab Malpractice		Senior Living Properties, LLC	100.00%	0		17
18	V	30	Depreciation		Senior Living Properties, LLC	100.00%	1,810	1,810	18
19	V	32	Interest		Senior Living Properties, LLC	100.00%	1,895	1,895	19
20	V	33	Real Estate Taxes		Senior Living Properties, LLC	100.00%	0		20
21	V	34	Rent-Facility & Grounds		Senior Living Properties, LLC	100.00%	5,119	5,119	21
22	V	35	Rent-Equipment & Vehicles		Senior Living Properties, LLC	100.00%	411	411	22
23	V	36	Loss, Goodwill, & Depreciation		Senior Living Properties, LLC	100.00%	286	286	23
24	V	0	0				0		24
25	V	0	0				0		25
26	V	0	0				0		26
27	V	0	0				0		27
28	V	0	0				0		28
29	V	0	0				0		29
30	V	0	0				0		30
31	V	0	0				0		31
32	V	0	0				0		32
33	V	0	0				0		33
34	V		0				0		34
35	V		0				0		35
36	V		0				0		36
37	V		0				0		37
38	V		0				0		38
39	Total			$			$ 20,598	$ * 20,598	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Senior Living Properties, LLC
Street Address: 12400 N. Meridian Street, Suite 180
City / State / Zip Code: Carmel, Indiana 46032
Phone Number: (317) 208-2740
Fax Number: (317) 575-2562

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	See attachment	See attachment	See attachment	$ 163	$	See attachme	$ 0	1
2	2	Food Purchase	See attachment	See attachment	See attachment	0		See attachment	0	2
3	3	Housekeeping	See attachment	See attachment	See attachment	0		See attachment	0	3
4	4	Laundry	See attachment	See attachment	See attachment	60		See attachment	0	4
5	5	Heat and Other Utilities	See attachment	See attachment	See attachment	18,884		See attachment	410	5
6	6	Maintenance	See attachment	See attachment	See attachment	741,985		See attachment	18,271	6
7	7	Waste Removal	See attachment	See attachment	See attachment	0		See attachment	0	7
8	10	Nursing & Medical Records	See attachment	See attachment	See attachment	300		See attachment	0	8
9	10a	Therapy	See attachment	See attachment	See attachment	0		See attachment	0	9
10	17	Administrative	See attachment	See attachment	See attachment	84,798		See attachment	2,086	10
11	19	Professional Services	See attachment	See attachment	See attachment	1,775,423		See attachment	40,115	11
12	20	Dues, Fees, Subscriptions & Prom	See attachment	See attachment	See attachment	76,549		See attachment	260	12
13	21	Clerical & General Office Expens	See attachment	See attachment	See attachment	3,248,251		See attachment	68,901	13
14	22	Employee Benefits & Payroll Taxe	See attachment	See attachment	See attachment	228,203		See attachment	10,157	14
15	24	Travel and Seminar	See attachment	See attachment	See attachment	821,540		See attachment	920	15
16	26	Insurance - Prop Liab Malpractic	See attachment	See attachment	See attachment	0		See attachment	0	16
17	30	Depreciation	See attachment	See attachment	See attachment	73,575		See attachment	1,810	17
18	32	Interest	See attachment	See attachment	See attachment	145,409		See attachment	1,895	18
19	33	Real Estate Taxes	See attachment	See attachment	See attachment	16		See attachment	0	19
20	34	Rent-Facility & Grounds	See attachment	See attachment	See attachment	208,088		See attachment	5,119	20
21	35	Rent-Equipment & Vehicles	See attachment	See attachment	See attachment	32,533		See attachment	411	21
22	36	Loss, Goodwill, & Depreciation	See attachment	See attachment	See attachment	12,011		See attachment	286	22
23	0	0				0				23
24	0	0				0				24
25	TOTALS					$ 7,467,788	$		$ 150,641	25

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
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15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
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19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	GMAC Comm Mort Corp		X	Acquisition	$16,717.00	2/6/98	$ 2,411,646	$	2/1/08	0.0681	$ 81,721	1
2	Complete Care Services		X	Acquisition	$622.00	2/6/98	106,710	112,627	2/6/08	N/A - None	N/A - None	2
3	Manager Note		X	Acquisition	$622.00	2/6/98	106,710	112,627	2/6/08	N/A - None	N/A - None	3
4	Bank of New York		x	Acquisition	$26,193.27	5/1/79	2,172,740	1,550,000	5/1/10	0.0825	163,864	4
5												5
	Working Capital											
6	Line of Credit		X	Working Capital	None	2/6/98	Various		Demand	Prime + 2%	18,484	6
7	Other Interest										31,563	7
8												8
9	TOTAL Facility Related				$44,154.27		$ 4,797,806	$ 1,775,254			$ 295,632	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,797,806	$ 1,775,254			$ 295,632	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	54,818	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	54,818	2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	54,817	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	54,817	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	52,236	8
	1998	52,999	9
	1999	53,467	10
	2000	41,549	11
	2001	54,818	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME OAKWOOD HEALTH CARE CENTER COUNTY HENRY

FACILITY IDPH LICENSE NUMBER 0043711

CONTACT PERSON REGARDING THIS REPORT William H. Keys

TELEPHONE (317) 208-2740 FAX #: (317)581-9513

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	025-03-401-008-0060	See Attached	$ 51,700.46	$ 51,700.46
2.	025-03-401-009-0060	See Attached	$ 857.98	$ 857.98
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 52,558.44	$ 52,558.44

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 35,875 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	362,419	1998	$ 35,152	1
2					2
3	TOTALS	362,419		$ 35,152	3

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$	-	$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	leasehold improvements (purchase price)			1998	228,513	19,043	12	19,043		92,494	9
10	leased building (purchase price)			1998	1,998,252	166,521	12	166,521		808,816	10
11	land improvement			1998	14,668	733	20	733		4,318	11
12	flag pole			1998	667	67	10	67		217	12
13	landscaping			1998	1,248	83	15	83		477	13
14	resurface parking lot			1998	35,386	4,423	8	4,423		18,798	14
15	hot water tank			1998	1,975	198	10	198		972	15
16	boiler repair			1998	1,307	109	12	109		515	16
17	roof vent			1998	937	85	11	85		373	17
18	100 series tackboards			1998	1,870	170	11	170		745	18
19	U-2 sound divider			1998	3,768	377	10	377		1,696	19
20	interior door closer			1998	694	63	11	63		269	20
21	new doors			1998	6,565	597	11	597		2,507	21
22	repair fire wall bath			1998	6,059	551	11	551		2,314	22
23	repair fire wall			1998	2,100	191	11	191		871	23
24	install sink disposal			1998	2,672	223	12	223		1,648	24
25	B series reverse osmosis system			1998	4,412	882	5	882		2,757	25
26	paint remodel therapy room			1998	191	19	10	19		121	26
27	signage			1998	464	93	5	93		306	27
28	track 12x8 w/90 degree bend			1998	64	6	10	6		24	28
29	sign posts, outside signs			1998	745	68	11	68		310	29
30	panic bars & extension rods			1998	1,300	130	10	130		497	30
31	borders therapy rm remodel			1998	249	23	11	23		91	31
32	remodel therapy room			1999	5,105	464	11	464		1,580	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	drapery	1999	$ 150	$ 15	10	$ 15	$	$ 58	37
38	wall mural	1999	500	100	5	100		383	38
39	office carpets	1999	1,481	296	5	296		1,135	39
40	carpets	1999	1,481	296	5	296		1,110	40
41	carpets	1999	1,106	221	5	221		755	41
42	covebase for carpet installation	1999	230	46	5	46		157	42
43	vinyl floor	1999	280	28	10	28		96	43
44	door alarm	1999	639	64	10	64		240	44
45	door alarm	1999	7,516	752	10	752		2,819	45
46	wallpaper	1999	976	195	5	195		667	46
47	wallpaper	1999	632	126	5	126		431	47
48	door alarm	1999	4,475	448	10	448		1,381	48
49	door alarm	1999	203	20	10	20		62	49
50	plumbing repair	1999	647	32	20	32		104	50
51	refridgerator	1999	486	49	10	49		155	51
52	cabinets	1999	8,668	578	15	578		1,830	52
53	building improvements - CK	2000	4,801	320	15	320		747	53
54	building improvements - INV	2000	806	54	15	54		126	54
55	wallpaper & border	2000	1,435	287	5	287		765	55
56	wallpaper & border	2000	764	153	5	153		382	56
57	install AOS 400 gallon storage tank	2000	5,985	855	7	855		2,209	57
58	boiler repairs	2000	1,657	237	7	237		758	58
59	install Tjerlund motor and wheel on power unit	2000	1,119	160	7	160		560	59
60									60
61	land improvement	1998	(14,668)	(733)	20	(733)		(4,318)	61
62									62
63	(DON'T ENTER BELOW THIS LINE)								63
64	Total (This Page)								64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,350,580	$ 199,718		$ 199,718	$	$ 955,328	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,350,580	$ 199,718		$ 199,718	$	$ 955,328	1
2									2
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5									5
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,350,580	$ 199,718		$ 199,718	$	$ 955,328	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,350,580	$ 199,718		$ 199,718	$	$ 955,328	1
2									2
3									3
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5									5
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,350,580	$ 199,718		$ 199,718	$	$ 955,328	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,350,580	$ 199,718		$ 199,718	$	$ 955,328	1
2									2
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,350,580	$ 199,718		$ 199,718	$	$ 955,328	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,350,580	$ 199,718		$ 199,718	$	$ 955,328	1
2									2
3									3
4									4
5									5
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,350,580	$ 199,718		$ 199,718	$	$ 955,328	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 2,350,580	$ 199,718		$ 199,718	$	$ 955,328	1
2									2
3									3
4									4
5									5
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,350,580	$ 199,718		$ 199,718	$	$ 955,328	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 2,350,580	$ 199,718		$ 199,718	$	$ 955,328	1
2									2
3									3
4									4
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,350,580	$ 199,718		$ 199,718	$	$ 955,328	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 2,350,580	$ 199,718		$ 199,718	$	$ 955,328	1
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,350,580	$ 199,718		$ 199,718	$	$ 955,328	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 2,350,580	$ 199,718		$ 199,718	$	$ 955,328	1
2									2
3									3
4									4
5									5
6									6
7									7
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,350,580	$ 199,718		$ 199,718	$	$ 955,328	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 262,946	$ 31,722	$ 31,722	$	Various	$ 162,892	71
72	Current Year Purchases	6,455	443	443		Various	443	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 269,401	$ 32,165	$ 32,165	$		$ 163,335	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,655,133	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 231,883	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 231,883	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,118,663	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 11,142 Description: Nursing - 972, Central Supply - 6166, Dietary - 2371, Plant - 402, Administrative - 820, Home Office - 411
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a, 3	hrs	$	1,360	$ 106,460	$ 590	1,360	$ 107,050	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		136	17,193	0	136	17,193	2
3	Licensed Recreational Therapist	10a, 3	hrs		0	0	46,617		46,617	3
4	Licensed Physical Therapist	10a, 3	hrs		2,076	153,559	369	2,076	153,928	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	3,572	$ 277,212	$ 47,576	3,572	$ 324,788	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 **Report Period Beginning:** 1/1/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 35,140	$	1
2	Cash-Patient Deposits	185,424		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	470,612		3
4	Supply Inventory (priced at)	19,273		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 710,449	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	35,152		13
14	Buildings, at Historical Cost	2,381,273		14
15	Leasehold Improvements, at Historical Cost	51,968		15
16	Equipment, at Historical Cost	269,402		16
17	Accumulated Depreciation (book methods)	(1,128,371)		17
18	Deferred Charges	1,667,461		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	(4,857,945)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ (1,581,060)	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ (870,611)	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 250,616	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,937		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	125,507		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	56,681		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other accrued expenses	48,870		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 505,611	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	225,253		39
40	Mortgage Payable	1,550,000		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,775,253	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,280,864	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,151,475)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (870,611)	$	48

***(See instructions.)**

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,510,142)	1
2	Restatements (describe):		2
3	**Restatements of Prior Year to allow rollforward**		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,510,142)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(668,987)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **PRIOR YR ADJ - DEPREC**	27,654	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (641,333)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (3,151,475)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,402,741	1
2	Discounts and Allowances for all Levels	(472,226)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,930,515	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	510,344	6
7	Oxygen	152,810	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 663,154	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	103	13
14	Non-Patient Meals	2,392	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	79,319	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	24,983	19
20	Radiology and X-Ray		20
21	Other Medical Services	64,609	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 171,406	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,623	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,623	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,769,698	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	837,914	31
32	Health Care	1,895,296	32
33	General Administration	927,516	33
	B. Capital Expense		
34	Ownership	611,477	34
	C. Ancillary Expense		
35	Special Cost Centers	56,982	35
36	Provider Participation Fee	109,500	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,438,685	40
41	**Income before Income Taxes (line 30 minus line 40)****	(668,987)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (668,987)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,318	3,688	$ 92,363	$ 25.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,991	14,378	254,832	17.72	3
4	Licensed Practical Nurses	21,471	23,174	354,170	15.28	4
5	Nurse Aides & Orderlies	60,208	64,609	540,429	8.36	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,305	6,018	64,937	10.79	8
9	Activity Director	2,002	2,171	17,217	7.93	9
10	Activity Assistants	5,019	5,422	35,763	6.60	10
11	Social Service Workers	5,549	6,192	68,397	11.05	11
12	Dietician	2,013	2,126	26,826	12.62	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,165	23,495	154,075	6.56	15
16	Dishwashers					16
17	Maintenance Workers	3,562	3,960	41,894	10.58	17
18	Housekeepers	14,956	16,012	112,790	7.04	18
19	Laundry	7,042	7,786	62,506	8.03	19
20	Administrator	2,149	2,358	77,318	32.79	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,922	9,729	115,429	11.86	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,916	2,264	29,720	13.13	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	178,588	193,382	$ 2,048,666 *	$ 10.59	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	135	$ 6,535	10, 3	50
51	Licensed Practical Nurses	32	1,156	10, 3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	167	$ 7,691		53

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Pat Thieben	Admin.	0	$ 77,318
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 77,318

B. Administrative - Other

Description	Amount
Contract Svcs - Administrator	$ 2,220
TOTAL (agree to Schedule V, line 17, col. 3)	$ 2,220
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal Fees	Various	$ 14,911
Patient Litigation	Various	
Payroll Processing	Various	642
Accounting	Various	6,500
EDP Services	Various	6,062
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 28,115

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 61,170
Unemployment Compensation Insurance	(4,846)
FICA Taxes	181,748
Employee Health Insurance	63,893
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
	0
	0
	0
Home Office Allocation	10,157
TOTAL (agree to Schedule V, line 22, col.8)	$ 312,122

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	8,596
Health Care Worker Background Check	
(Indicate # of checks performed 59)	
Dues & Subscriptions	2,126
Advertising & Public Relations	
Home Office Allocation	260
Less: Public Relations Expense	( )
Non-allowable advertising	
Yellow page advertising	
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,982

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	16,249
Seminar Expense	1,215
Business Meals	125
Home Office Allocation	920
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 18,509

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number OAKWOOD HEALTH CARE CENTER # 0043711 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **6,159** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **109,500**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,392**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.